WYA-MED-3- Diet Prescription for Meals at School Food Allergies/Food Sensitivities/Religious or other Convictions

Student's Name: _____ Date of Birth: _____ Age: _____

Food or Medication Allergies: _____

Section A: To be completed by the child's Physician or a recognized Medical Authority (if describing a disability)

Does the child have a disability? ☐ Yes ☐ No

If Yes, describe the major life activity affected by the disability _____

Does the child have a non-disabling medical condition? ☐ Yes ☐ No

If Yes, describe the medical condition _____

Does the child have special nutritional or feeding needs? ☐ Yes ☐ No

If Yes, describe the specific need _____

If you answered YES to any of the questions above, complete the following and return to WYA Admissions or fax (360) 473-2623.

Section B: Diet Prescription- please attach additional instructions if necessary.
(To be completed by the child's Physician or a Recognized Medical Authority)
If foods are listed to be omitted from the diet, foods to substitute must be provided. Note-new USDA guidance that juice is not a substitute for milk for students without disabilities.

Foods to Omit:	Foods to Substitute:
_____	_____
_____	_____
_____	_____
_____	_____

I certify that the above named student needs special school meals prepared or served as described above because of the student's disability or chronic medical condition.

_____ _____
Physician or Recognized Medical Authority Signature Date signed

Name: _____ Office Phone: _____ Fax: _____
Type or Print

I understand that if my child's medical or healthy needs change, it is my responsibility to notify Nutrition Services and have a new Diet Prescription for Meals at School form completed.

_____ _____ _____
Parent/Guardian's Signature Home Phone Number Date signed

I give School Nurse permission to speak with the above named Physician or Authorized Medical Authority to discuss the dietary needs
described above. _____ (parent/guardian's initials and date).